Provider Enrollment Form

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

We are authorized by law (30 USC 901-945 et seq. and 20 CFR 725.703) and Public Law 106-398 and 20 CFR 30.701 to collect the information requested on this report. The reason this information is collected is to ensure accurate and timely payment of medical services to the provider. Collection of information is voluntary.

OMB No. 1215-0137
Expires: 01-31-02

I. Are you applying for a new enrollment or updating your record with our program?

New Enrollment ☐
Update Request ☐

If updating your record, please enter your Provider Number here ☐☐☐☐☐☐

and complete the appropriate sections only

II. **Check the provider type below that most closely describes the medical service(s) you provide-**

Provider Type

(1) ☐ Physician, Private Practice
(2) ☐ Physician Corporation or Group Practice
(3) ☐ Hospital
(4) ☐ Durable Medical Equipment Supplier
(5) ☐ Pharmacy

Provider Type

(6) ☐ Pulmonary Rehabilitation
(7) ☐ Skilled Nursing Facility, Nursing Home, Hospice or Home Health Agency
(8) ☐ Ambulance, Other

Please Explain Other

III. **Will you accept referrals?** Yes ☐ No ☐

IV. **Please complete one of the following three boxes (A, B or C).**

A. Physician Provider (Private Practice)

Name: First	M. I.	Last	M. D.	D.O.

Tax ID Number	Specialty
Board Certified Yes ☐ No ☐	

Social Security Number	License Number	License Expiration Date

B. Physician Provider (Corporation or Group Practice)

Name (Corporation)	
Tax ID Number	Specialty

For each physician billing under your provider number, list the following: (continue on separate sheet, if necessary)

Name	Board Certified Yes	Board Certified No	Social Security Number	License Number

C. Non-Physician Provider (Hospital, Durable Medical Equipment Supplier, Pharmacy, Pulmonary Rehabilitation Clinic, Skilled Nursing Facility, Nursing Home Facility, Home Health Agency, Ambulance, Other)

Official name of your Facility or Agency	Billing name as it will appear on your bill
Tax ID Number	Medical service you provide
License Number	License Expiration Date

ALL PROVIDERS MUST COMPLETE THE REVERSE SIDE.

V.

A. Local address and telephone number

Street Number and Name		
City	State	Zip Code
	AL	
Area Code	Number	

B. Billing or mailing address - indicate "same" if identical to A. (This is where your checks and remittance reports will be sent.)

Street Number and Name		
City	state	Zip Code
	AL	

VI. NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal laws.

Signature (Provider or Representative and Title)	Date

Please return this completed form to the appropriate program at the following address to prevent a delay in the processing of your bills. To be enrolled/updated in both the Black Lung and Energy Employees Programs, SEPARATE forms must be submitted to each program.

Reset **Print**

Federal Black Lung Program
P.O. Box 828
Lanham - Seabrook, Maryland 20703 - 0828

If you have any questions regarding the completion of the form, please call
Toll Free: 1-800-638-7072

Energy Employees Occupational Illness Compensation Program
P.O. Box 727
Lanham - Seabrook, Maryland 20703 - 0727

If you have any questions regarding the completion of the form, please call
Toll Free: 1-866-272-2682

Privacy Act Statement

The following information is provided in accordance with the Privacy Act of 1974 and as amended (5 U.S.C.552a). (1) Collection of this information is authorized by the Black Lung Benefits Act (30 U.S.C. 901-945) and the Energy Employees Occupational Illness Compensation Program Act (P.L. 106-398 - EEOICPA). (2) The information in this form will be used to ensure accurate medical provider information for payment of medical bills. Disclosure of your social security number and completion of this form is voluntary; however, failure to provide this information may result in bill payment delays. (3) This information may be furnished to data processing contractors, to the Department of Labor and to the IRS in accordance with the law. (4) Furnishing all requested information will facilitate accurate and timely payment of medical services to the provider.

NOTICE: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

Public Burden Statement

We estimate that it will take an average of 7 minutes to complete this information collection, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this survey, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Room C3524, 200 Constitution Avenue, N.W., Washington, D.C. 2021 0.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE